cooked to look like the waiting times were not as long as they were, allegations such as those at the Veterans' Administration hospital in Phoenix, where allegedly there were secret waiting lists where 40 veterans died waiting to get health care, and the secret waiting list was being created to make the backlog appear not as serious as it was.

As we discuss and debate all the numbers on wait times and backlogs, it is important as always, whenever we are talking about statistics and numbers, to remember these are real human beings and these are our veterans with real individual stories.

They represent people such as Dale Richardson, who is a Vietnam veteran from East Texas who died of cancer after reportedly waiting 2 months to hear back from the VA about scheduling chemotherapy treatments. They represent people such as Thomas Breen, a Navy veteran who, similar to Mr. Richardson, died of cancer after a 2-month period in which he reportedly waited in vain to hear back from the VA about an appointment time. They also represent people such as Edward Laird whose story was written up in the Los Angeles Times this last weekend. Mr. Laird is a Navy veteran, age 76, who discovered a couple of unusual marks on his nose, and so he went to the doctor at the Phoenix VA hospital to get it checked out, and according to the Los Angeles Times, the doctor said he needed a biopsy, but it took almost 2 years before Mr. Laird was allowed to see a VA specialist, and when he finally did get to see the specialist, he was told that the biopsy was unnecessary and so it wasn't done.

Mr. Laird found it hard to believe, but that is what they told him. Unfortunately, by the time he got the VA hospital in Phoenix to agree to see him—the situation with his nose which he could tell as simply a layman had gotten worse—Mr. Laird was ultimately diagnosed with cancer and literally half of his nose had to be taken off because of cancer.

As Mr. Laird told the Los Angeles Times: ''I have no nose, and I have to put an ice cream stick up my nose at night so I can breathe.''

I will just mention one other story from the Phoenix system. Earlier this month a woman named Kim Sertich told the Arizona Republic that her father received such poor care at the Phoenix VA that she was forced to pay for private care until he ultimately died in 2011. In her own words, she said:

> Whenever anyone asked how my father died, I say, ''From being in the VA hospital.'' The icing on the cake is when I received a letter of condolence from the hospital, and they had the wrong name for my dad.

It is obvious from anecdote to anecdote, from the drip, drip, drip that then turns into a flood, there is something terribly wrong with the health care and the way the Veterans' Administration is administering 589,000 claims, with more than half of them backlogged, according to the standards and criteria of the Veterans' Administration.

We have known that the backlog has been a problem for years. Indeed, we have tried to come together in a bipartisan way and legislatively through the national defense authorization bill, where we added money. We have added resources to the VA system. Obviously, we have not gotten to the bottom of the problem. Part of it, I am afraid, is systemic, and some of it, sadly, is part of the bureaucratic culture at the VA, where accountability is unknown. You don't get credit for doing a good job. You don't get demerits for doing a bad job. There is no accountability, and this is what you get without accountability.

Not only is the VA system failing to provide our military heroes with reliable health care that they deserve, there are also news reports that the VA across the country has been falsifying appointment data in hopes of covering up wait times. Sadly, some of those allegations have come from my State. We have allegations of data manipulation of these appointment times in Austin, where I live, and Harlingen, in South Texas, and San Antonio and Waco.

For that matter, a former VA doctor named Richard Krugman told the Washington Examiner that up to 15,000 VA patients in South Texas were either denied colonoscopies,—of course, those are cancer screening examinations—or they were forced to endure long, pointless delays. Dr. Krugman fears that many of those patients simply died awaiting their cancer screening or awaiting treatment. If the problems at the VA are just a fraction as serious as what they appear from the news reports that we see day in and day out or the stories I recounted today, if they are a fraction as severe as what they appear to be, we have a national scandal of the highest order.

Let's be clear about what is happening. U.S. military veterans are literally dying because of bureaucratic failures and in some instances bureaucratic fraud. There is simply no excuse for what reportedly happened in Harlingen, Phoenix or in any of the cities where veterans or veterans officials have made their allegations. Yet it disturbs me that I am not sure the President is taking this with the requisite urgency. Apparently it is in the talking points to say, when somebody raises this scandal—I think Jay Carney said the President is mad as hell. That is what Eric Shinseki said when he testified before the Senate Veterans' Affairs Committee last week, but that is, frankly, not good enough. We need less rhetoric and more action.

For starters, the President has still not demanded the resignation of the person in charge of the Department of Veterans Affairs. We all admire General Shinseki for his service in the U.S. Army, but he on his watch has presided over some of the biggest scandals at the VA in history. It is painfully clear, no matter what you think about General Shinseki—and I admire him for his service in the Army, but it is painfully clear the VA needs a fresh new set of eyes, new leadership, in order to recover, reform, and regain the confidence of America's veterans.

President Obama still stands by his VA Secretary while nothing seems to be happening. Yes, we read about where there is an audit here, audit there, but we need top-to-bottom review and reform and we need to see the VA once again regain America's confidence.

It is not just me who is saying this. One of the largest veterans affairs organizations in America, the American Legion, has called on Secretary Shinseki to step down and new leadership to be appointed.

Here is just another example of the administration's unserious response to this scandal. The person who has been nominated to serve as the VA Under Secretary of Health, Dr. Murawsky, currently oversees a VA health care system in Illinois that was recently rocked by all-too-familiar allegations of secret waiting lists. I note that Dr. Murawsky spent 2 years as the direct supervisor of Sharon Helman, who worked in the Great Lakes Health Care System before becoming Director of the Phoenix system. As we all know, Ms. Helman was placed on administrative leave after the Phoenix VA was charged with creating secret waiting lists of its own.

For these reasons I asked President Obama to withdraw Dr. Murawsky's nomination. We need a clean break. We need new leadership, a fresh set of eyes, and we need a sense of urgency in what is a growing scandal. As I said a moment ago, if even a fraction of these failures and abuses were true, it would represent a national scandal of the highest order. It is not enough for the VA Secretary to say, I am ''mad as hell.'' That doesn't solve anybody's problems. That doesn't fix what is broken in the VA health care system. What America's veterans want and deserve is bold reform and new leadership. President Obama has the power to make that happen, and it is long past time for him to use it.

I yield the floor.

ORDER OF BUSINESS

The PRESIDING OFFICER. Under the previous order, the time until 5:30 p.m. will be equally divided and controlled between the two leaders or their designees.

The Senator from Michigan.

THE MIDDLE CLASS

Ms. STABENOW. Madam President, I am here to talk about the future of our country and the future of our middle class, which I know the Presiding Officer cares deeply about as well.

A few years ago in Michigan something quite extraordinary happened. In 1914 a man named Henry Ford did